ASSOCIATES IN DERMATOLOGY AND COSMETIC SURGERY, P.A.
The Millburn Laser Center
Board Certified Dermatologists

PLEASE PRINT CLEARLY!

DATE_____

PATIENTS INFORMATION

Last Name_____ **First**_____ **Male** ____ **Female**____

Race_____ **Ethnicity**_____

Address_____ **City**_____

Apartment #_____ **State**____ **Zip**_____-_____

Date of Birth_____ **Social Security**_____

Phone #_____ **Cell #**_____

Preferred Method of Contact
(Please Circle One) Home Cell

Language Preference_____ **Email Address**_____

Marital Status (Please Circle One)
Single Married Widowed Divorced Domestic Partner

Name of Primary Care Physician :_____
Address & Phone Number:_____

Name of Pharmacy:_____
Address & Phone Number:_____

Insurance Information

Primary Insurance
Policy Holders Name _____
Relationship to Patient _____
Date of Birth _____

Secondary Insurance
Policy Holders Name _____
Relationship to Patient _____
Date of Birth _____

-TURN OVER-

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose you IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Worker's Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

13. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

14. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

15. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**. Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of the IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to tile your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of health and Human Services. To file a complaint with our practice, contact **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.** If you are not satisfied with the maner in which this office handles a complaint, you may submit a formal complaint to: Region II – New York (New Jersey, New York, Puerto Rico, Virgin Islands), Linda Colon, Acting Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, Jacob Javis Federal Building, 26 Federal Plaza, Suite 3312, New York, NY 10278. Voice Phone: (212) 264-3313. FAX (212) 264-3039. TDD (212) 264-2355.

8. Right to provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke you authorization, we will no longer use or disclose our IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

9. Changes to this Notice of Privacy Practices. We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041**.

Associates in Dermatology and Cosmetic Surgery

Millburn Laser Center

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations
Created as a Result
of the Health Insurance Portablity
and Accountability Act
of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Please Read This Notice Carefully

(973) 376-8500

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning our IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Associates in Dermatology and Cosmetic Surgery, Millburn Laser Center, 12 East Willow Street, Millburn, NJ 07041, (973) 376-8500.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal state or local law.

9. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices.
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct in our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted with access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety or another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of Associates in Dermatology and Cosmetic Surgery P.A.'s Notice Privacy Practices.

_____ _____

Signature of Patient (18 years of age or Guardian) **Date**

Financial Agreement and Authorization of Treatment

I Authorize use of this form on all my insurances submissions

I authorize release of information to all my insurances

I authorize my doctor to act as my agent in obtaining payment

I understand payment directly to my doctor

It is agreed that payments will not be delayed or withheld due to my insurance coverage or the pendency of claims thereon

I permit a copy of this authorization to be used in place of original

Name (Please Print) _____

Signature_____ Date_____
(18 years of age or Guardian)

Self Paying Patients ONLY

I understand that since I am not covered by a medical plan, I will be fully responsible for fees accumulated for services rendered by Associates in Dermatology and Cosmetic Surgery, P.A.

Patient Signature_____

Associates in Dermatology and Cosmetic Surgery-The Millburn Laser Center

Appointment Cancellation Policy

Patient's Name: _____ Date of Birth: _____

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit.

If an appointment is not cancelled at least 24 hours in advance and you do not arrive for your appointment, you will be charged a $75.00 fee. No further appointments will be scheduled for you until the $75.00 cancellation fee is paid. This fee will not be reimbursed by your insurance company, nor will it be credited toward a future appointment.

Since we certainly understand that illness or other problems can occur, and sometimes without any warning, we will not charge you for your first missed or cancelled appointment.

This policy is in effect for all appointments at all of our office locations. Please acknowledge that you have had the opportunity to review this policy by signing below.

Thank you for your understanding and cooperation.

_____ _____
Patient Signature Date

_____ _____
Witness Date

I am the parent or guardian of the patient.

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

Associates in Dermatology and Cosmetic Surgery-The Millburn Laser Center

Credit Card Policy

Patient's Name:_____ Date of Birth: _____

The undersigned agrees that all information provided to the applicable financial Institution is accurate and complete.

The office will NO LONGER be sending statements. If the office is not contacted within 2-3 weeks of receipt of the Explanation of Benefits by your Insurance carrier, then the credit card on file will be processed for payment of the balance due. The balance may include co-pay, deductible, or co-insurance.

By completing and signing this form, you authorize Associates in Dermatology and Cosmetic Surgery of Essex and Union PA - The Millburn Laser Center (The Practice) to charge your credit card on file for any balance due as set forth on the Explanation of Benefits from your Insurance company that Is not paid by your Insurance company (the "Patient Responsibility"). The Explanation of Benefits from your insurance company determines the Patient Responsibility.

I have read this Consent and Authorization to Process Credit Card Payments and agree to the terms and conditions set forth above. I hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of the practice. Furthermore, I agree to assign all health insurance benefits directly to Associates in Dermatology and Cosmetic Surgery of Essex and Union PA - The Millburn Laser Center and understand that I am responsible for any costs of Patient Responsibility not covered by my health Insurance which shall be charged to the credit card as set forth above.

Credit Cardholder's Name: _____

Signature: _____ Date: _____

Patient ID Number: _____ Office Use:_____